Green Mountain Care Board

Accountable Care Organization (ACO)

Reporting Manual

Entity:	OneCare Vermont ACO, LLC
Version:	FY 2021 Original Version (v.21.1.0)
Date:	June 18, 2021
Version Notes:	UNDER REVIEW – ALL CONTENT SUBJECT TO CHANGE
	Report templates, deadlines, and reporting history are under review and subject to change. The Green Mountain Care Board will publish an updated version of this manual Quarterly as reporting is due, templates are reviewed and edited, and reporting history is updated.

ACO Reporting Manual Version Tracking: OneCare Vermont ACO, LLC

Date	Version*	Author(s)	Revisions	GMCB Review	OCVT Review
6/18/2021	FY 2021 Original Version (v.21.1.0) OCVT_FY21_GMCB_ACO_Reporting_Manual.v.21.1.0	GMCB (Marisa M; Sarah T)	N/A	N/A	N/A

* Version control key: *v=version, 21=last two digits of the year issued, 1=first year issued, 0=original version for the year; Date=date issued*

ACO Reporting Manual Index: OneCare Vermont ACO, LLC

Rpt. No.	Name of Report	Frequency[1,2]	Report Purpose	Report Template	Category	Citations/Reference	GMCB teams[3]
1	**Scale Target Initiatives and Program Alignment Form (for each payer program)**	Budget submission (Oct 1); Final payer contracts/revised budget (TBD Spring)	To verify that programs qualify as scale target initiatives per the APM Agreement.	FORM.docx	APM – Scale; Payer Programs	FY21 #2; APM Agreement: Section 6	ACO, APM
2	**Attribution Report**	Quarterly (Apr, Jul, Oct, Jan)	To report attributed lives by payer program, by month, and by quarter.	Excel	APM – Scale	5.403(a)10.; 5.501(a); FY21 #1	ACO, APM, Data
3	**Provider contracts**	Budget submission (Oct 1)	To review ACO affiliated provider agreements.	None	Provider Network	FY21 #5; 5.205(a); 5.501	ACO
4	**Hospital Maximum Risk Addenda (for each participating hospital)**	Annual (Within 10 business days of execution)	To quantify hospital maximum risk on an annual basis.	None	Provider Network	FY21 #5-7; 5.205(a); 5.501	ACO
5	**ACO Network Lists**	Budget submission (Oct 1)	To produce a standard curated ACO network list to track the network year over year.	Excel	Provider Network	5.205(a); 5.501; (12/9/20 staff presentation)	ACO, Data
6	**Network Development Strategy**	Annual (April)	To report on provider network development and selection criteria.	Narrative	Provider Network	FY20 #1; 5.205	ACO
7	**Signed payer contracts (for each payer program)**	Budget submission (Oct 1); Revised budget (Within 10 business days of execution)	To review ACO affiliated payer agreements.	None	Payer Programs	FY21 #3,6-7; 5.403(a)10, 5.501	ACO, APM
8	**Actuarial Certifications for Commercial Benchmarks**	Annual (Oct)	To verify each commercial (including self-funded) benchmark is adequate but not excessive.	Narrative	Payer Programs	FY21 #3.c.ii.(a)	ACO
9	**Quality Measures Scorecards (for each payer program)**	Annual (Fall)	To report final (year-end) payer-specific quality results and score.	Per APM	Payer Programs; Quality/Pop. Health; APM	5.403(a)4; APM Agreement: Section 7	ACO, APM
10	**Utilization Management Plan**	TBD: Last submitted 2/21/18	To report monitoring and evaluation plan for services provided to attributed members by the ACO network; to ensure provision of medically necessary care with optimal quality outcomes and cost containment.	TBD	Quality/Pop. Health	5.206; 5.207; 4.403(a)(13); (12/9/20 staff presentation)	ACO
11	**Population Health Investments Evaluation Work Plan (Population health and care coordination evaluation plan)**	TBD: Last submitted 6/30/20	To report the workplan to evaluate the effectiveness of population health investments.	TBD	Quality/Pop. Health	5.206; 5.403(a)(16)-(20); 5.501(a); FY20 #18; 12/9/20 staff presentation	ACO

[1] If a month is given, the deadline is the last business day of that month, unless otherwise specified. Days are business days.
[2] Resubmissions are to confirm and highlight any changes to the original submission, unless otherwise specified.
[3] GMCB team abbreviations: ACO = ACO Oversight (Health Systems Policy) team; APM = All-Payer Model (Health Systems Policy) team; Data = Data & Analytics team; HSF = Health Systems Finance (Hospital Budgets) team.

12	**Clinical Focus Areas (previously Clinical Priorities)**	Annual (April)	To report Clinical Focus Areas annually endorsed by the Clinical and Quality Advisory Committee and the Population Health Strategy Committee.	Narrative	Quality/Pop. Health	Certification; 5.206; and § 9382(a)(2)	ACO
13	**Quality Management Improvement Work Plan**	Annual (April)	To report the work plan to monitor quality assurance, performance measurement, and performance improvement.	Narrative	Quality/Pop. Health	Certification; 5.206 and § 9382(a)(2); Medicaid contract	ACO
14	**Collaboration with Designated Agencies on 42 CFR Part 2**	TBD (in Certification Form)	CareNavigator provides a common consent and redisclosure process to ensure care team members subject to 42 CFR Part 2 regulations can actively participate in treatment.	TBD	Quality/Pop. Health	Certification; 5.205; 5.206; and § 9382(a)(2)	ACO
15	**Addressing Childhood Adversity**	TBD (in Certification Form)	To report on criteria requiring the ACO to provide connections and incentives for preventing and addressing the impact of childhood adversity.	TBD	Quality/Pop. Health	Certification 5.301(c)(2)(N); § 9382(a)(17); and 5.403(a)(20)	ACO
16	**ACO Performance Dashboard**	TBD	To provide a systematic way to understand the impacts of ACO programs through reporting population health and financial data.	TBD	Financial; Quality/Pop. Health	FY20 #19; 5.403(a)(4), (11), (13), (16)-(22)	ACO, Data
17	**Revised budget**	Annual (May or TBD)	To submit a revised budget for the current year reflecting final payer contracts, attribution, source of revenue and revised expenses, hospital dues, hospital risk, changes to the risk model, final description of population health programs, and any other reporting required by the Board (e.g. VBIF, strategic planning).	Excel	Financial	FY21 #6-7; 5.403(a)	ACO
18	**Financial statements**	Quarterly (May, Aug, Nov, Feb)	To evaluate OneCare's financial performance throughout the calendar year relative to the approved budget.	Excel	Financial	FY21 #1; 5.204; 5.403(a)(3), (22); 5.501(a);	ACO, HSF
19	**ACO Management Compensation**	Annual	To report benchmark information on salaries and benefits and to monitor that administrative costs and management salaries are not excessive.	Excel; (Narrative: TBD)	Financial	FY21 #8; 5.403(a)(1), (3); § 9382 (b)(1)(D), (M)	ACO, HSF
20	**Audited financial statements**	Annual (Sept)	To submit audited financial information and note disclosures for prior time periods to evaluate the audited actuals relative to the approved budget.	None	Financial	FY21 #13; 5.204; 5.403(a)(3), (22); 5.501(a), (d);	ACO, HSF
21	**Crosswalk submitted actuals to audited financial statements**	Annual (April)	To allow for a reconciliation between the submitted budgets/actuals to audited financials.	Excel	Financial	FY21 #13; 5.204; 5.403(a)(3), (22); 5.501(a), (d);	ACO, HSF
22	**Comprehensive Payment Reform (CPR) Program Report**	Annual; Semi-Annual (TBD)	To monitor performance of the CPR program which is designed to allow greater participation from independent primary care providers and bring more providers into a capitated payment model.	TBD	Financial	Certification 5.301(c)(2)(N); FY21 #10, and § 9382(a)(3)	ACO
23	**Settlement Reports**	Annual (Nov)	To ensure the ACO executed the risk model as described in their approved budget.	Excel	Financial	FY21 #5, 5.403(a)(3), (4), (22); 5.501; APM Agreement §6	ACO, APM
24	**Complaint and Grievance Report ("Member & Provider Communications Report")**	Semi-annual (July, Jan)	It is required that all certified ACOs submit complaint and grievance reports to the GMCB and Health Care Advocate no less than twice a year.	Excel; Narrative elements	Patient Protections	Certification 5.208(i) ; 5.403(a)(7)	ACO

25	**Beneficiary Notification Letters**	Annual (March)	To verify that OneCare is alerting individuals that are attributed to the ACO network that they are an ACO beneficiary, the GMCB requires that the ACO provides a copy of the notification letter sent to the beneficiaries.	None	Patient Protections	Certification 5.208(j)	ACO
26	**Policies, procedures, plans checklist**	Monthly	GMCB Rule 5.000 requires that all certified ACOs in Vermont maintain specific standards and operational procedures. To validate that an ACO is meeting requirements laid out in Rule 5.000, the GMCB requires that policies, procedures, and plans are submitted on a monthly basis as changes are made. The GMCB verifies criteria in Rule 5.000 is being met by evaluating policies, procedures, and plans.	Excel	Certification	Rule 5.000; 5.301(c); 5.501(c)	ACO
27	**Operating Agreement**	Annual or within 15 days per 5.501(c)	Per GMCB Rule 5.000, § 5.501(c) it is required that all certified ACOs submit their operating agreement or bylaws to the regulating entity.	None	Certification	Rule 5.501; 5.403(a)(1); 5.301(c)(2)(B)	ACO
28	**Governance, leadership, and organizational charts**	Annual or within 15 days per 5.501(c)	Per GMCB Rule 5.000, § 5.202, it is required that certified ACOs "must have a governance structure that reasonably and equitably represents ACO participants." To verify ACOs continue to meet this requirement, the GMCB asks for the submission of a governance chart. ACOs must also submit leadership and organizational charts to satisfy the requirements laid out in GMCB Rule 5.000, § 5.203.	None	Certification	Rule 5.202; 5.203; 5.301(c)(2)(A)-(I); 5.403(a)(1); 5.501(c); § 9382(a)(1)	ACO
29	**Committee charters**	Annual	Per GMCB Rule 5.000, § 5.301(c)(2)(G), ACOs are required to submit "descriptions of the purpose and composition of each of the [ACO's] committees, advisory boards, councils, and similar groups." The GMCB upholds this standard by reviewing descriptions of each committee and collecting selected committee charters.	None	Certification	Rule 5.301(c)(2)(A)-(G); 5.202; 5.403(a)(1)	ACO
30	**Demonstration of data analytics**	FY21; Ad-hoc (last done 2/20/18)	To describe and demonstrate the ACO's health information technology systems and how these systems are used by the ACO, e.g., to coordinate care and measure performance, to support data collection and integration and data analytics.	None	Financial; Quality/Pop. Health	FY21 #14; 5.210; 5.301(c); 5.501	ACO, Data
31	**Fixed prospective payment target and strategy**	One-time (7/1/21)	OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.	Reporting guidance	Financial	FY21 #15; 5.209; 5.301(c)(2)(N); 5.403(a)(8)-(10)	ACO
32	**ACO Return on investment analysis**	One-time (2023)	Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.	TBD	Financial	FY21 #12; 5.203; 5.403(2), (3)	ACO, Data
33	**ACO Strategic Plan**	3-year; FY21-23 submitted 5/24/21	To report the ACO's mission, vision, values, and core strategies and capabilities.	None	General	FY21 #7.j; 5.403(a);	ACO

#) REPORT TEMPLATE

Report Purpose:

Deadline:

Instructions:

Definitions:

Report Template:

Notes:

Version	Submitted to GMCB

INSERT A PAGE BREAK AT THE END OF THE REPORT TEMPLATE SO EACH REPORT IS ON ITS OWN PAGE OR PAGES

1) Scale Target Initiatives and Program Alignment

Report Purpose: To ensure scale target initiatives are qualifying per the All-Payer ACO Model Agreement (Section 6.b.)

Deadline: October 1 budget submission and/or within 10 days of payer contract execution.

Instructions: Complete the "ACO Scale Target Initiatives and Program Alignment Forms." Requests must be made in writing for confidentiality for any information OneCare believes to be exempt from public record. Additionally, the GMCB will ask OneCare Vermont to review and confirm accuracy of the tables when preparing the Annual Scale Targets and Alignment Report as required by Section 6.j.i. of the Agreement, ensuring that no changes would disqualify a program.

Report Template: (example image is p.2 of 7)

Payer Contract: Click or tap here to enter text. **Contract Period:** Start Date to End Date **Date Signed:** Click or tap here to enter text.
Financial Arrangement – Shared Savings and/or Shared Risk Arrangements
Are shared savings possible? * Choose an item.
Does shared savings arrangement meet minimum requirements of 30% of the difference between actual and expected spending (see Section 6.b of the All-Payer ACO Model Agreement)? * Choose an item.
Describe shared savings and shared risk arrangement(s): Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Payment Mechanisms – Payer/ACO Relationship
Describe payment mechanism(s) between payer and ACO (AIPBP, FFS, etc.): Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Payment Mechanisms – ACO/Provider Relationship
Describe payment mechanism(s) between ACO and ACO provider network: Click or tap here to enter text.
ACO Provider Agreement Reference(s): Click or tap here to enter text.
Services Included in Financial Targets (Total Cost of Care)
Services Included in Financial Targets: *Complete **Appendix A, Services Included in Financial Targets**, for all ACO-payer contracts. (Services must be comparable to All-Payer Financial Target Services as defined in section 1.f of the All-Payer ACO Model Agreement, to qualify as Scale Target ACO Initiative) **
Contract Reference(s): Click or tap here to enter text.
Quality Measurement
Is financial arrangement tied to quality of care or the health of aligned beneficiaries? * Choose an item.
Describe methodology for linking payments to quality of care or health of aligned beneficiaries (e.g., withhold, gate and ladder, etc.): Click or tap here to enter text.
Quality Measures: *Complete **Appendix B, Quality Measures**, for all ACO-payer contracts.*
Contract Reference(s): Click or tap here to enter text.
Attribution Methodology
Describe attribution methodology: Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Patient Protections
Describe patient protections included in ACO contracts or internal policies: Click or tap here to enter text.
Contract and Policy Reference(s): Click or tap here to enter text.

Version	Submitted to GMCB
FY18 Scale Target Initiatives	10/20/17
FY19 Scale Target Initiatives	10/1/18
FY20 Scale Target Initiatives	10/1/19

FY21 Scale Target Initiatives	10/1/20
FY22 Scale Target Initiatives	Upcoming 2021

2) Attribution Report

Report Purpose: To report attributed lives by payer program, by month, and by quarter.

Deadline: Quarterly (April, July, October, January)

Instructions:

1. Provide the final number of attributed lives by payer program, by month, and by quarter.
2. Payer program and year fields and definitions are to be updated annually.
3. Provide final attribution numbers at the end of each quarter and update any changes to previously submitted data.
4. Please note updated cells by highlighting in yellow.

Definitions:

BCBS QHP – BCBSVT Qualified Health Plan attributed lives

MVP QHP – MVP Qualified Health Plan attributed lives

BCBS LG Full-Ins – BCBSVT Fully Insured Large Group

BCBS LG Self-Ins – BCBSVT Self-Insured Large Group

BCBS BEE – BCBSVT Blue Edge Enterprise Group

BCBS LG and BEE make up the "BCBSVT Primary Program"

Report Template:

2021												
	Q1			Q2			Q3			Q4		
Program	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicare												
Medicaid												
BCBS QHP												
MVP QHP												
BCBS LG Full-Ins												
BCBS LG Self-Ins												
BCBS BEE												

Notes:

- Generally, due to timing of reporting and natural attrition, Medicare numbers reported quarterly by OneCare will not align with CMS numbers used in GMCB annual reporting.

Version	Submitted to GMCB
FY18 Year End Attribution Report	03/21/18
FY19 Quarterly Attribution Reports	04/30/19, 07/31/19, 10/31/19, 01/31/20
FY20 Quarterly Attribution Reports	04/30/20, 07/31/20, 10/31/20, 01/31/21
FY21 Quarterly Attribution Reports	04/30/21, Q2-Q4 upcoming

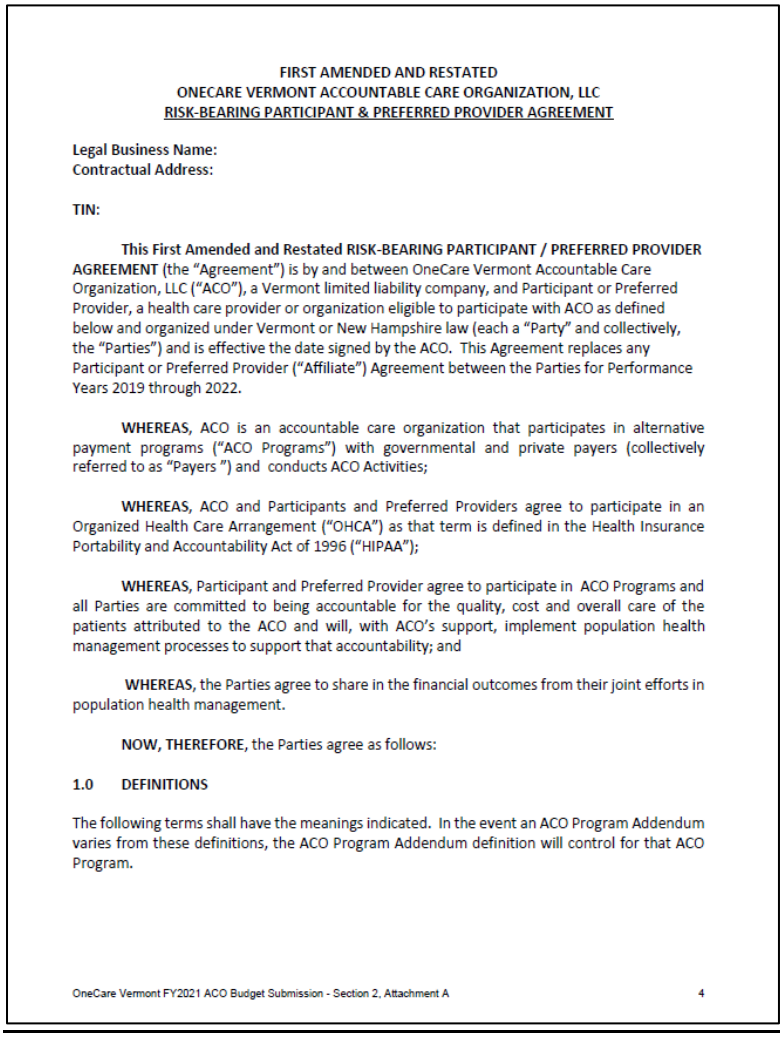
3) Provider Contracts

Report Purpose: To validate and verify ACO affiliated provider agreements.

Deadline: Submit with the annual budget submission on October 1.

Instructions: Upon finalization of provider contracts, submit copies of each type of provider contract, agreement, and addendum for the fiscal year (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).

Report Template:



FIRST AMENDED AND RESTATED
ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
RISK-BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT

Legal Business Name:
Contractual Address:

TIN:

This First Amended and Restated RISK-BEARING PARTICIPANT / PREFERRED PROVIDER AGREEMENT (the "Agreement") is by and between OneCare Vermont Accountable Care Organization, LLC ("ACO"), a Vermont limited liability company, and Participant or Preferred Provider, a health care provider or organization eligible to participate with ACO as defined below and organized under Vermont or New Hampshire law (each a "Party" and collectively, the "Parties") and is effective the date signed by the ACO. This Agreement replaces any Participant or Preferred Provider ("Affiliate") Agreement between the Parties for Performance Years 2019 through 2022.

WHEREAS, ACO is an accountable care organization that participates in alternative payment programs ("ACO Programs") with governmental and private payers (collectively referred to as "Payers ") and conducts ACO Activities;

WHEREAS, ACO and Participants and Preferred Providers agree to participate in an Organized Health Care Arrangement ("OHCA") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

WHEREAS, Participant and Preferred Provider agree to participate in ACO Programs and all Parties are committed to being accountable for the quality, cost and overall care of the patients attributed to the ACO and will, with ACO's support, implement population health management processes to support that accountability; and

WHEREAS, the Parties agree to share in the financial outcomes from their joint efforts in population health management.

NOW, THEREFORE, the Parties agree as follows:

1.0 DEFINITIONS

The following terms shall have the meanings indicated. In the event an ACO Program Addendum varies from these definitions, the ACO Program Addendum definition will control for that ACO Program.

OneCare Vermont FY2021 ACO Budget Submission - Section 2, Attachment A 4

Version	Submitted to GMCB
FY18 Provider Contracts	10/20/17
FY19 Provider Contracts	10/1/18
FY20 Provider Contracts	10/1/19
FY21 Provider Contracts	10/1/20
FY22 Provider Contracts	Upcoming 2021

4) Hospital Maximum Risk Addenda

Report purpose: To quantify hospital maximum risk on an annual basis.

Deadline: Annual (Within 10 business days of execution)

Instructions: Submit hospital maximum risk addenda to provider contracts for the fiscal year.

Report Template:

Notes:

Version	Submitted to GMCB
FY19 Hospital Maximum Risk Addenda	09/25/19

5) ACO Network Lists

Report purpose: To produce a standard curated ACO network list to track the network year over year.

Deadline: Annual (October 1)

Instructions: Complete Budget Guidance Appendices 2.1 and 2.2.

Definitions: See Excel workbook.

Report Template: See Excel workbook.

Notes:

Version	Submitted to GMCB
FY18 Network Lists	10/20/17
FY19 Network Lists	10/1/18
FY20 Network Lists	10/1/19
FY21 Network Lists	10/1/20
FY22 Network Lists	Upcoming 2021

6) Network Development Strategy

Report Purpose: To report on provider network development and selection criteria. To evaluate an ACO's strategy to increase network participation to meet scale target goals set forth in Vermont's All-Payer ACO Model Agreement.

Deadline: Annual (April)

Instructions: In narrative format, describe the network development strategy for the upcoming year and any anticipated changes to the provider network including areas of growth, areas of decline and general observations as to what is driving participation decisions and how these changes affect the overall budget. Discuss both the challenges and opportunities associated with network recruitment activities. Report to include:

a. A definition for ACO "network composition" necessary to maximize value-based incentives;
b. Provider outreach strategy;
c. Provider recruitment and acceptance criteria;
d. Network development timeline;
e. Providers dropping out of the network (quantify) and reasons why; and
f. Challenges to network development.

Definitions:

A definition for ACO "network composition" necessary to maximize value-based incentives (provided 4/5/20): *The network of providers participating in an ACO that voluntarily come together to share resources and expertise to promote health. Network providers agree to be collectively accountable (clinically and financially) for the quality, cost, and access of the populations they serve and actively engage in appropriate systems transformation efforts.*

Report Template:

Notes:

Version	Submitted to GMCB
2021 Network Development Strategy	4/5/2020
2022 Network Development Strategy	5/28/2021

7) Signed Payer Contracts

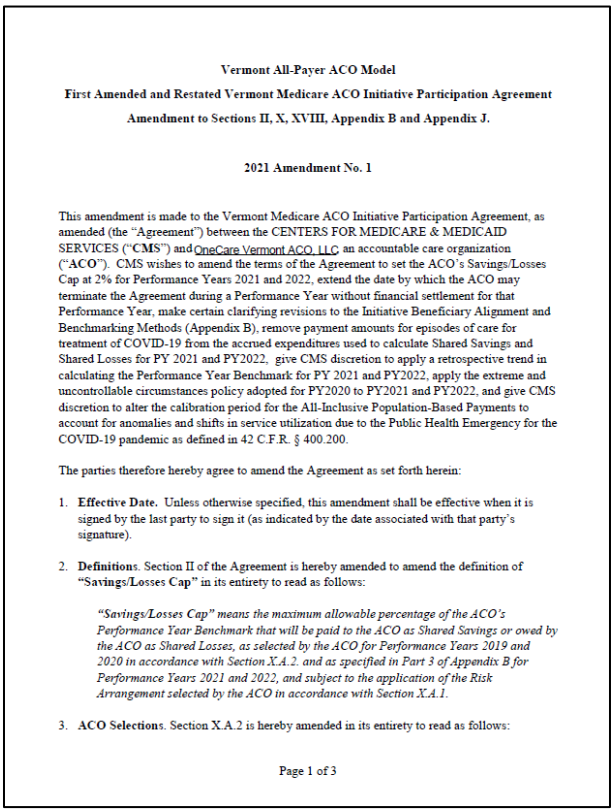
Report Purpose: To validate and verify ACO affiliated payer agreements.

Deadline: Submit as executed and include an update with the annual budget submission on October 1.

Instructions: Upon finalization of provider contracts (within 10 days of execution), submit copies of each type of provider contract, agreement, and addendum for the fiscal year (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).

Definitions:

Report Template:



Vermont All-Payer ACO Model

First Amended and Restated Vermont Medicare ACO Initiative Participation Agreement

Amendment to Sections II, X, XVIII, Appendix B and Appendix J.

2021 Amendment No. 1

This amendment is made to the Vermont Medicare ACO Initiative Participation Agreement, as amended (the "Agreement") between the CENTERS FOR MEDICARE & MEDICAID SERVICES ("**CMS**") and OneCare Vermont ACO, LLC an accountable care organization ("**ACO**"). CMS wishes to amend the terms of the Agreement to set the ACO's Savings/Losses Cap at 2% for Performance Years 2021 and 2022, extend the date by which the ACO may terminate the Agreement during a Performance Year without financial settlement for that Performance Year, make certain clarifying revisions to the Initiative Beneficiary Alignment and Benchmarking Methods (Appendix B), remove payment amounts for episodes of care for treatment of COVID-19 from the accrued expenditures used to calculate Shared Savings and Shared Losses for PY 2021 and PY2022, give CMS discretion to apply a retrospective trend in calculating the Performance Year Benchmark for PY 2021 and PY2022, apply the extreme and uncontrollable circumstances policy adopted for PY2020 to PY2021 and PY2022, and give CMS discretion to alter the calibration period for the All-Inclusive Population-Based Payments to account for anomalies and shifts in service utilization due to the Public Health Emergency for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200.

The parties therefore hereby agree to amend the Agreement as set forth herein:

1. **Effective Date.** Unless otherwise specified, this amendment shall be effective when it is signed by the last party to sign it (as indicated by the date associated with that party's signature).

2. **Definitions**. Section II of the Agreement is hereby amended to amend the definition of **"Savings/Losses Cap"** in its entirety to read as follows:

   "Savings/Losses Cap" means the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, as selected by the ACO for Performance Years 2019 and 2020 in accordance with Section X.A.2. and as specified in Part 3 of Appendix B for Performance Years 2021 and 2022, and subject to the application of the Risk Arrangement selected by the ACO in accordance with Section X.A.1.

3. **ACO Selections**. Section X.A.2 is hereby amended in its entirety to read as follows:

Page 1 of 3

Notes:

Version	Submitted to GMCB
FY18 Payer Contracts (Medicaid, UVMMC Self-funded, BCBSVT, Medicare)	02/6/18, 05/23/18, 05/23/18, 06/26/18 (respectively)
FY19 Payer Contracts	05/30/19
FY20 Payer Contracts	05/5/20
FY21 Payer Contracts	05/21/21

8) Actuarial Certifications for Commercial Benchmarks

Report Purpose: Actuarial certifications for each commercial (including self-funded) benchmark stating that the benchmark is adequate but not excessive. Actuarial certifications are required because the financial targets for commercial ACO programs are typically not finalized until after the Board issues the budget order. For FY19 and FY20, the GMCB approved budgets reflecting yet-to-be negotiated commercial targets, provided targets met certain requirements, including that the targets be certified by an actuary as "adequate" but "not excessive."

Deadline: Annual (October)

Instructions:

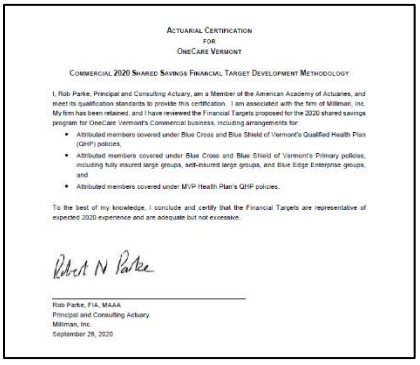
1. Submit documentation signed by an actuary retained by the ACO attesting that the actuary has reviewed the financial targets proposed for each commercial ACO program for the budget year and certifies, to the best of their knowledge, that the financial targets are representative of expected budget year experience and are adequate but not excessive.
2. Documentation should include a brief response to the following questions. What data does the consulting actuary receive and explain why it is (or is not) sufficient to provide an actuarial certification? Has the ACO reviewed that budget order requirement and actuarial review with commercial insurers?

Definitions:

Adequate – A certification that the financial targets are "adequate" provides the Board with some assurance that the ACO is not taking on inappropriate risk and that the financial targets the ACO is agreeing to do not threaten the solvency of the ACO or the Vermont hospitals that ultimately bear the risk under OneCare's delegated risk model.

Not Excessive – An ACO is a legal structure that allows health care providers to jointly negotiate with health insurers. A certification that a commercial program's financial target is "not excessive" provides the Board with some assurance that the product of these negotiations is based on the application of actuarial science to data, not providers' bargaining power.

Report Template:



ACTUARIAL CERTIFICATION
FOR
ONECARE VERMONT

COMMERCIAL 2020 SHARED SAVINGS FINANCIAL TARGET DEVELOPMENT METHODOLOGY

I, Rob Parke, Principal and Consulting Actuary, am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification. I am associated with the firm of Milliman, Inc. My firm has been retained, and I have reviewed the Financial Targets proposed for the 2020 shared savings program for OneCare Vermont's Commercial business, including arrangements for:

- Attributed members covered under Blue Cross and Blue Shield of Vermont's Qualified Health Plan (QHP) policies,
- Attributed members covered under Blue Cross and Blue Shield of Vermont's Primary policies, including fully insured large groups, self-insured large groups, and Blue Edge Enterprise groups, and
- Attributed members covered under MVP Health Plan's QHP policies.

To the best of my knowledge, I conclude and certify that the Financial Targets are representative of expected 2020 experience and are adequate but not excessive.

Robert N Parke

Rob Parke, FIA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
September 28, 2020

Version	Submitted to GMCB

9) Quality Measure Scorecards

Report Purpose: Final (year-end) payer-specific quality results and score.

Deadline: Annual (Fall)

Instructions: Use existing reporting format (example image below) and submit to GMCB for each allowable scale-qualifying payer program.

Report Template:

OneCare Vermont

Vermont Medicaid Next Generation Program
2019 Quality Measure Scores: Medicaid
Performance Year 3: Reporting and Performance Measures

Measure	Y1 2017	Y2 2018	Y3 2019	Quality Compass 2018 National Medicaid Benchmarks 25th (0.5 point)	50th (1 point)	75th (1.5 points)	90th (2 points)	Rate 2017	Rate 2018	Rate 2019	Num	Den	Bonus Points	Quality Points
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	P	P	P	10.07	16.26	24.48	32.15	30.25	29.15	37.15	227	611	1.00	2.00
30 Day Follow-Up after Discharge from the ED for Mental Health	P	P	P	45.58	52.79	66.25	74.47	80.93	81.74	85.53	532	622	0.00	2.00
Adolescent Well-Care Visits	P	P	P	45.74	54.57	61.99	66.80	57.50	56.40	57.35	8,789	15,326	0.00	1.00
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	P	P	P	-	-	-	-	1.48	1.02	0.88	17	1,940	N/A	1.00
Developmental Screening in First 3 Years of Life	P	P	P	17.80	39.80	53.90	N/A	59.74	59.27	62.10	3,107	5,003	1.00	2.00
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	P	P	P	46.96	38.20	33.09	29.68	31.52	33.33	25.61	95	371	1.00	2.00
Hypertension: Controlling High Blood Pressure	P	P	P	49.27	58.68	65.75	71.04	64.61	63.90	62.63	233	372	0.00	1.00
Initiation of Alcohol and Other Drug Dependence Treatment	P	P	P	38.62	42.22	46.40	50.20	35.39	38.87	40.77	806	1,977	0.00	0.50
Engagement of Alcohol and Other Drug Dependence Treatment	P	P	P	9.11	13.69	17.74	21.40	17.63	16.21	20.23	400	1,977	1.00	1.50
Screening for Clinical Depression and Follow-Up Plan	P	P	P	-	-	-	-	47.37	43.43	51.96	159	306	N/A	2.00
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	R	R	R	29.61	36.54	45.79	54.13	37.02	37.50	40.85	306	749	N/A	-
Tobacco Use Assessment and Tobacco Cessation Intervention	R	R	R	-	-	-	-	N/A	60.76	83.87	312	372	N/A	-

* Inverse rate measure

Points Earned: 19.00
Total Possible Points: 20.00
2019 Final Score: 95.00%

Notes:

Version	Submitted to GMCB
FY18 Quality Measure Scorecard	10/2/19
FY19 Quality Measure Scorecard	10/1/20
FY20 Quality Measure Scorecard	upcoming
FY21 Quality Measure Scorecard	upcoming

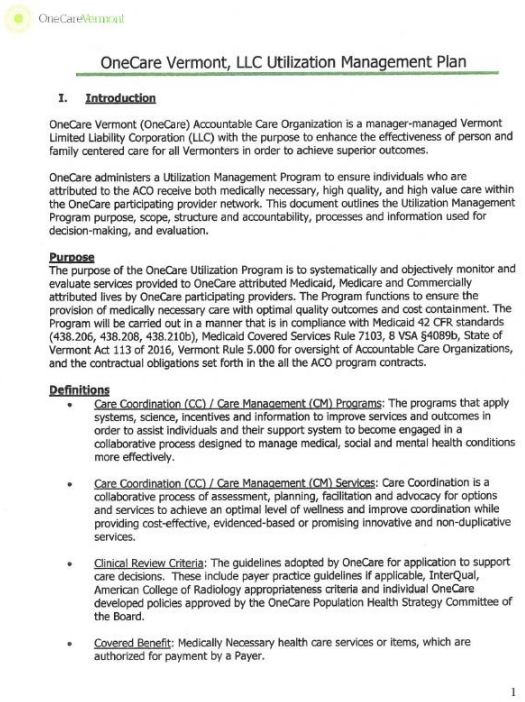
10) Utilization Management Plan

Report purpose: To report monitoring and evaluation of services provided to attributed members by the ACO network; to ensure provision of medically necessary care with optimal quality outcomes and cost containment.

Deadline: TBD

Instructions: Submit the organization's Utilization Management Plan.

Report Template:



OneCareVermont

OneCare Vermont, LLC Utilization Management Plan

I. Introduction

OneCare Vermont (OneCare) Accountable Care Organization is a manager-managed Vermont Limited Liability Corporation (LLC) with the purpose to enhance the effectiveness of person and family centered care for all Vermonters in order to achieve superior outcomes.

OneCare administers a Utilization Management Program to ensure individuals who are attributed to the ACO receive both medically necessary, high quality, and high value care within the OneCare participating provider network. This document outlines the Utilization Management Program purpose, scope, structure and accountability, processes and information used for decision-making, and evaluation.

Purpose

The purpose of the OneCare Utilization Program is to systematically and objectively monitor and evaluate services provided to OneCare attributed Medicaid, Medicare and Commercially attributed lives by OneCare participating providers. The Program functions to ensure the provision of medically necessary care with optimal quality outcomes and cost containment. The Program will be carried out in a manner that is in compliance with Medicaid 42 CFR standards (438.206, 438.208, 438.210b), Medicaid Covered Services Rule 7103, 8 VSA §4089b, State of Vermont Act 113 of 2016, Vermont Rule 5.000 for oversight of Accountable Care Organizations, and the contractual obligations set forth in the all the ACO program contracts.

Definitions

- Care Coordination (CC) / Care Management (CM) Programs: The programs that apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively.
- Care Coordination (CC) / Care Management (CM) Services: Care Coordination is a collaborative process of assessment, planning, facilitation and advocacy for options and services to achieve an optimal level of wellness and improve coordination while providing cost-effective, evidenced-based or promising innovative and non-duplicative services.
- Clinical Review Criteria: The guidelines adopted by OneCare for application to support care decisions. These include payer practice guidelines if applicable, InterQual, American College of Radiology appropriateness criteria and individual OneCare developed policies approved by the OneCare Population Health Strategy Committee of the Board.
- Covered Benefit: Medically Necessary health care services or items, which are authorized for payment by a Payer.

1

Notes:

Version	Submitted to GMCB
Utilization Management Plan	02/21/2018

11) Population Health Investments Evaluation Work Plan

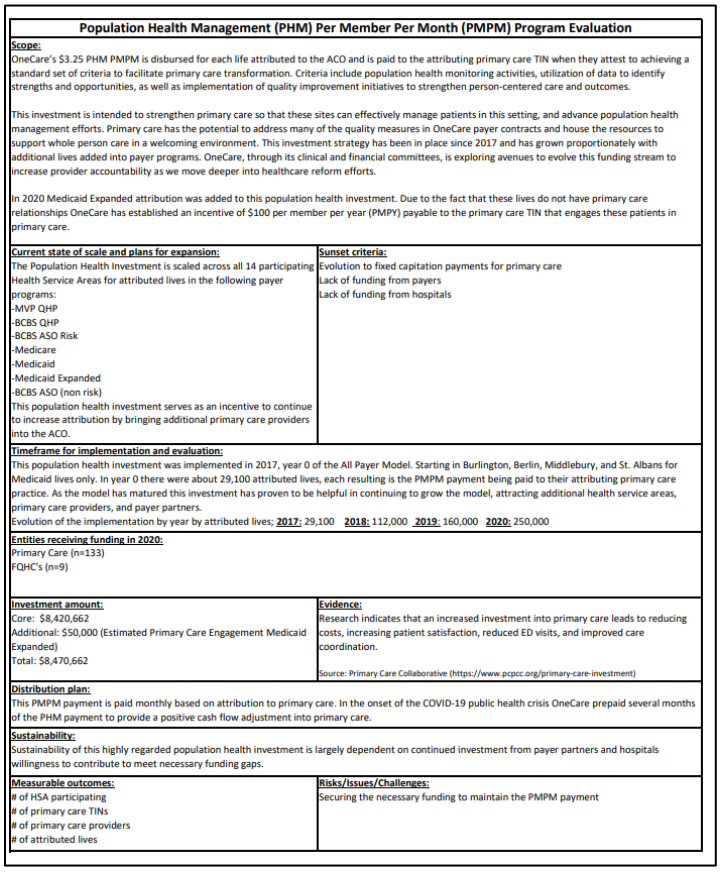
Report Purpose: Workplan to evaluate the effectiveness of population health investments.

Deadline: TBD

Instructions: OneCare must develop a workplan to evaluate the effectiveness of its population health investments including analysis of how to scale those that are successful, sunset those that are not, and report on opportunities for sustainability. This plan must include the identity of each entity receiving funding, the funding amount, any evidence supporting the purpose(s) of the corresponding project, a distribution plan for the funding, the scope of project, relevant timeframe(s) for implementation and evaluation, any measurable outcomes, and any risks, issues, or challenges. This workplan may exclude the Blueprint for Health investments (SASH, CHT, and PCMH). For competitive grants, OneCare should provide an explanation of the criteria by which it evaluates proposals for funding.

Definitions: TBD

Report Template: Last submitted version found with FY20 budget order deliverables here.



Population Health Management (PHM) Per Member Per Month (PMPM) Program Evaluation

Scope:
OneCare's $3.25 PHM PMPM is disbursed for each life attributed to the ACO and is paid to the attributing primary care TIN when they attest to achieving a standard set of criteria to facilitate primary care transformation. Criteria include population health monitoring activities, utilization of data to identify strengths and opportunities, as well as implementation of quality improvement initiatives to strengthen person-centered care and outcomes.

This investment is intended to strengthen primary care so that these sites can effectively manage patients in this setting, and advance population health management efforts. Primary care has the potential to address many of the quality measures in OneCare payer contracts and house the resources to support whole person care in a welcoming environment. This investment strategy has been in place since 2017 and has grown proportionately with additional lives added into payer programs. OneCare, through its clinical and financial committees, is exploring avenues to evolve this funding stream to increase provider accountability as we move deeper into healthcare reform efforts.

In 2020 Medicaid Expanded attribution was added to this population health investment. Due to the fact that these lives do not have primary care relationships OneCare has established an incentive of $100 per member per year (PMPY) payable to the primary care TIN that engages these patients in primary care.

Current state of scale and plans for expansion:	**Sunset criteria:**
The Population Health Investment is scaled across all 14 participating Health Service Areas for attributed lives in the following payer programs: -MVP QHP -BCBS QHP -BCBS ASO Risk -Medicare -Medicaid -Medicaid Expanded -BCBS ASO (non risk) This population health investment serves as an incentive to continue to increase attribution by bringing additional primary care providers into the ACO.	Evolution to fixed capitation payments for primary care Lack of funding from payers Lack of funding from hospitals

Timeframe for implementation and evaluation:
This population health investment was implemented in 2017, year 0 of the All Payer Model. Starting in Burlington, Berlin, Middlebury, and St. Albans for Medicaid lives only. In year 0 there were about 29,100 attributed lives, each resulting is the PMPM payment being paid to their attributing primary care practice. As the model has matured this investment has proven to be helpful in continuing to grow the model, attracting additional health service areas, primary care providers, and payer partners.
Evolution of the implementation by year by attributed lives; **2017:** 29,100 **2018:** 112,000 **2019:** 160,000 **2020:** 250,000

Entities receiving funding in 2020:
Primary Care (n=133)
FQHC's (n=9)

Investment amount:	**Evidence:**
Core: $8,420,662 Additional: $50,000 (Estimated Primary Care Engagement Medicaid Expanded) Total: $8,470,662	Research indicates that an increased investment into primary care leads to reducing costs, increasing patient satisfaction, reduced ED visits, and improved care coordination. Source: Primary Care Collaborative (https://www.pcpcc.org/primary-care-investment)

Distribution plan:
This PMPM payment is paid monthly based on attribution to primary care. In the onset of the COVID-19 public health crisis OneCare prepaid several months of the PHM payment to provide a positive cash flow adjustment into primary care.

Sustainability:
Sustainability of this highly regarded population health investment is largely dependent on continued investment from payer partners and hospitals willingness to contribute to meet necessary funding gaps.

Measurable outcomes:	**Risks/Issues/Challenges:**
# of HSA participating # of primary care TINs # of primary care providers # of attributed lives	Securing the necessary funding to maintain the PMPM payment

Notes:

Version	Submitted to GMCB
FY20 Condition #18	6/30/2020

12) Clinical Focus Areas

Report purpose: Clinical Focus Areas[4] annually developed through the Clinical and Quality Advisory Committee and the Population Health Strategy Committee. Clinical Focus Areas are developed through regional collaboration across HSAs.

Deadline: Annual (April)

Instructions:

1. In narrative format describe:
    a. the process for development and approval of Clinical Focus Areas,
    b. the criteria for selecting Clinical Focus Areas,
    c. how Clinical Focus Areas fit into OneCare's overall Model of Care,
    d. changes to Clinical Focus Areas from the prior year and why those changes were made,
    e. how progress on Clinical Focus Areas is measured and reported; and
    f. the targets for improvement

Definitions:

Clinical Focus Areas (previously Clinical Priorities) – [[definition from OneCare needed?]]

Image of report template:

Report format is at the discretion of OneCare provided that all elements of the instructions are included. Example graphic is from 2019. 2020 Focus Areas were provided in narrative format without a graphic, which is also acceptable.

Version	Submitted to GMCB
2019 Clinical Priorities	04/30/19
2020 Clinical Focus Areas	3/31/20
2021 Clinical Focus Areas	4/30/21
2022 Clinical Focus Areas	

[4] Clinical Focus Areas were called Clinical Priorities in prior years (2019).

13) Quality Management Improvement Work Plan

Report Purpose: To report the work plan to monitor quality assurance, performance measurement, and performance improvement.

Deadline: Annual (April)

Instructions: Please submit a work plan that details the ACO's quality assurance activities and performance management tasks. For each measure, please define and submit the aim, goal, measure, and key strategies. Additionally, please include the scope and population of each activity, the functional area, the person responsible, the planned activity name, data source, data collection methodology, reporting frequency, and status.

Definitions:

Report Template:

OneCare Vermont

2021 Quality Improvement Plan

BACKGROUND:

OneCare's Quality team is committed to designing and implementing quality improvement activities within the OneCare Vermont network. The aim is to promote a high value health care delivery system that improves population health by enhancing access to Primary Care, reducing death due to suicide and drug overdose, and reducing prevalence and morbidity of chronic disease. Improvements in population health and best practice protocols are reflected within performance rates of nationally recognized quality measures. Quality measures are an integral component of OneCare's payer programs and regulatory commitments. OneCare's Quality team members serve as subject matter experts on all ACO quality measures, data collection, and evidence based Process Improvement (PI) techniques that facilitate continuous improvement. OneCare provides financial incentives to its network for high quality measure performance through the Value Based Incentive Fund (VBIF).

Notes:

Version	Submitted to GMCB
2019 Quality Improvement Plan	4/30/19
2020 Quality Improvement Plan	07/27/20
2021 Quality Improvement Plan	4/29/21

14) Collaboration with Designated Agencies on 42 CFR Part 2

Report Purpose: CareNavigator provides a common consent and redisclosure process to ensure care team members subject to 42 CFR Part 2 regulations can actively participate in treatment.

2019 Certification Eligibility Verification Memo: https://gmcboard.vermont.gov/sites/gmcb/files/Updated%20Memo%20re%202019%20Certification%20Eligibility%20for%20OneCare%20Vermont.pdf

> *"CareNavigator allows information sharing across the continuum and can be used to identify key patient panels, including mental health diagnoses such as anxiety, depression, and bipolar disorder. CareNavigator has also provided a common consent and redisclosure process to ensure care team members subject to 42 CFR Part 2 regulations can actively participate in treatment. The patient maintains the right to refuse to share their information."*
>
> *"We recommend that OneCare submit a report regarding its collaboration with the Designated Agencies on a 42 CFR Part 2 common consent and re-disclosure process."*

Deadline: TBD

Instructions: TBD

Definitions: TBD

Report Template: TBD

Notes:

- UNDER REVIEW: Topic being discussed by the HIE Subcommittee and VITL.

Version	Submitted to GMCB

15) Addressing Childhood Adversity

Report Purpose: To report on criteria requiring the ACO to provide connections and incentives for preventing and addressing the impact of childhood adversity.

2019 Certification Eligibility Memo: https://gmcboard.vermont.gov/sites/gmcb/files/Updated%20Memo%20re%202019%20Certification%20Eligibility%20for%20OneCare%20Vermont.pdf

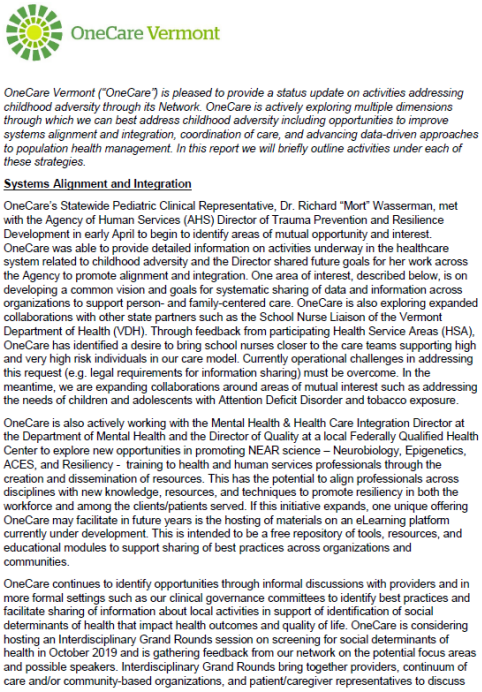
> "Childhood Adversity: We recommend that OneCare provide a timeline for its 2019 plan to address childhood adversity. This should include reporting on the projects highlighted in this section, including: 1) creation of new social determinants of health risk scores; 2) how ACEs screening tools are being incorporated into EHRs; 3) the DULCE program expansion; 4) how OneCare will use its analytic capacities to identify cost and utilization drivers to help justify additional resources for childhood trauma, and any additional initiatives OneCare will be starting."

Deadline: TBD

Instructions: Through the annual Certification Verification Form, please provide a report detailing OneCare's strategy for addressing childhood adversity within its network. Discuss specifically how OneCare is looking to improve systems alignment and integration, coordination of care, and use data drive approaches to improve population health management to address childhood adversity.

Definitions: TBD

Report Template: TBD



OneCare Vermont

OneCare Vermont ("OneCare") is pleased to provide a status update on activities addressing childhood adversity through its Network. OneCare is actively exploring multiple dimensions through which we can best address childhood adversity including opportunities to improve systems alignment and integration, coordination of care, and advancing data-driven approaches to population health management. In this report we will briefly outline activities under each of these strategies.

Systems Alignment and Integration

OneCare's Statewide Pediatric Clinical Representative, Dr. Richard "Mort" Wasserman, met with the Agency of Human Services (AHS) Director of Trauma Prevention and Resilience Development in early April to begin to identify areas of mutual opportunity and interest. OneCare was able to provide detailed information on activities underway in the healthcare system related to childhood adversity and the Director shared future goals for her work across the Agency to promote alignment and integration. One area of interest, described below, is on developing a common vision and goals for systematic sharing of data and information across organizations to support person- and family-centered care. OneCare is also exploring expanded collaborations with other state partners such as the School Nurse Liaison of the Vermont Department of Health (VDH). Through feedback from participating Health Service Areas (HSA), OneCare has identified a desire to bring school nurses closer to the care teams supporting high and very high risk individuals in our care model. Currently operational challenges in addressing this request (e.g. legal requirements for information sharing) must be overcome. In the meantime, we are expanding collaborations around areas of mutual interest such as addressing the needs of children and adolescents with Attention Deficit Disorder and tobacco exposure.

OneCare is also actively working with the Mental Health & Health Care Integration Director at the Department of Mental Health and the Director of Quality at a local Federally Qualified Health Center to explore new opportunities in promoting NEAR science – Neurobiology, Epigenetics, ACES, and Resiliency - training to health and human services professionals through the creation and dissemination of resources. This has the potential to align professionals across disciplines with new knowledge, resources, and techniques to promote resiliency in both the workforce and among the clients/patients served. If this initiative expands, one unique offering OneCare may facilitate in future years is the hosting of materials on an eLearning platform currently under development. This is intended to be a free repository of tools, resources, and educational modules to support sharing of best practices across organizations and communities.

OneCare continues to identify opportunities through informal discussions with providers and in more formal settings such as our clinical governance committees to identify best practices and facilitate sharing of information about local activities in support of identification of social determinants of health that impact health outcomes and quality of life. OneCare is considering hosting an Interdisciplinary Grand Rounds session on screening for social determinants of health in October 2019 and is gathering feedback from our network on the potential focus areas and possible speakers. Interdisciplinary Grand Rounds bring together providers, continuum of care and/or community-based organizations, and patient/caregiver representatives to discuss

Notes:

Version	Submitted to GMCB
1Q19 Reporting	4/30/2019
FY21 Certification submission	8/31/2020

16) ACO Performance Dashboard

Report Purpose: To provide a systematic way to understand the impacts of ACO programs through reporting population health and financial data.

Deadline: TBD

Instructions: OneCare must submit to the Board a prototype for an ACO performance dashboard and a proposed plan to implement the performance dashboard by December 31, 2020. GMCB staff will work with OneCare to determine the required form and content for the submission and to establish appropriate methodologies for reporting quality results in such a way to allow for valid comparisons where feasible. At a minimum, the dashboard shall profile population health and financial data by HSA and payer in a way that promotes variational analysis across HSAs and readily reconciles to Board approved and projected fiscal year budgets and population health performance targets. The Board will also provide an opportunity for the Health Care Advocate to provide input into the dashboard, including methodologies for quality reporting (FY20, #19).

Definitions:

Report Template:

Notes: A standardized template is still in development.

Version	Submitted to GMCB
2019 Performance Dashboard (FY20 #19)	1/14/2021

17) Revised Budget

Report Purpose: To submit a revised budget for the current year reflecting final payer contracts, attribution, source of revenue and revised expenses, hospital dues, hospital risk, changes to the risk model, final description of population health programs, and any other reporting required by the Board (e.g., VBIF, strategic planning).

Deadline: Submitted annually in the spring. Date dependent on finalized contracts and data processing.

Instructions: On an annual basis (date to be determined by the annual budget order), please submit a revised budget that is based on final attribution. Specifically note all changes from the initial submission. OneCare is also required to present the revised budget to the GMCB at a public meeting. All of the following topics and supporting documents are required to be submitted:

a) Final payer contracts;
b) Attribution by payer;
c) A revised budget, using a template provided by GMCB staff;
d) Final descriptions of OneCare's population health initiatives;
e) Hospital dues for 2020 by hospital;
f) Hospital risk for 2020 by hospital and payer;
g) Documentation of any changes to the overall risk model for 2020;
h) Source of funds for its 2020 population health management programs; and
i) Any other information the Board deems relevant to ensuring compliance with this order.

Definitions:

Report Template: See financial workbook.

Notes:

Version	Submitted to GMCB
FY20 Revised Budget	7/20/2020; 7/24/21 presentation
FY21 Revised Budget	5/24/2021; 5/26/21 presentation

18) Financial Statements

Report Purpose: To evaluate OneCare's financial performance throughout the calendar year, and review alignment to budget.

Deadline: Quarterly (May, Aug, Nov, Feb)

Instructions: Please complete and submit the following financial templates on a quarterly basis, upon approval of OneCare's Board of Managers.

- Balance Sheet
- Income Statement – Full Accountability
- Cash Flow
- Variance Analysis
- Sources/Uses
- PMPM Revenue by Payer
- Hospital Participation
- ACO Management Compensation
- PHM Expense Breakout

Financial templates must be submitted following approval from OneCare's Board of Managers according to the schedule established by OneCare and the GMCB.

Definitions:

Report Template: See financial workbook.

Notes:

Version	Submitted to GMCB
FY19 Quarterly Financial Statements	05/31/19, 08/31/19, 11/30/19, 02/28/20
FY20 Quarterly Financial Statements	05/31/20, 08/31/20, 11/30/20, 02/28/21
FY21 Quarterly Financial Statements	05/31/21, Q2-Q4 upcoming

19) ACO Management Compensation

Report Purpose: To ensure that administrative costs and management salaries are not excessive.

Deadline: Appears in FY21 Budget Order Condition #8; however, pieces of this reporting may be required annually by the GMCB or incorporated in to budget guidance.

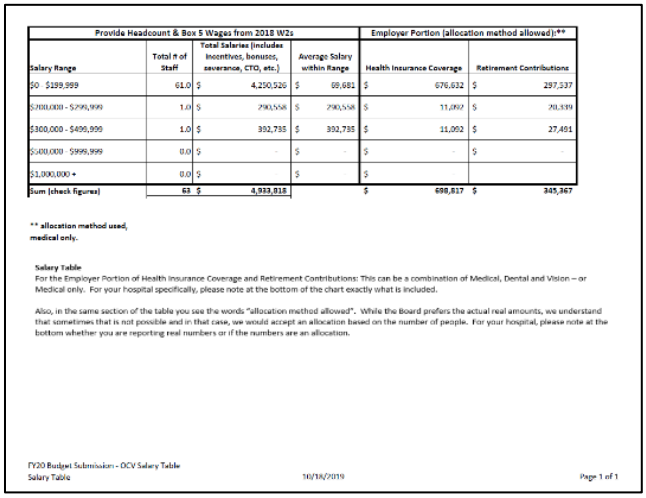
Instructions: Submit benchmark information on salaries and benefits according to the following guidance (proposed reporting from FY20 hospital budget guidance, adapted for ACO guidance):

Salary Information

1. Submit a full copy of the ACO's most recent Form 990, including the most current version of Schedule H that has been submitted to the Internal Revenue Service as part of the hospital organization's Form 990 reporting obligations under Section 501(c)(3) of the Internal Revenue Code.
2. Submit the hospital's policy or policies on executive, provider, and non-medical staff compensation.
3. Identify:
   i. Outside consultants relied on for benchmarking;
   ii. Peer groups to which the ACO benchmarks;
   iii. Compensation targets in terms of percentiles for each staff category; and
   iv. The ACO's actual compensation level, compared to target, for each employee group.

Definitions:

Report Template:



Provide Headcount & Box 5 Wages from 2018 W2s				Employer Portion (allocation method allowed)**	
Salary Range	Total # of Staff	Total Salaries (includes incentives, bonuses, severance, CTO, etc.)	Average Salary within Range	Health Insurance Coverage	Retirement Contributions
$0 - $199,999	61.0	$ 4,250,526	$ 69,681	$ 676,632	$ 297,537
$200,000 - $299,999	1.0	$ 290,558	$ 290,558	$ 11,092	$ 20,339
$300,000 - $499,999	1.0	$ 392,735	$ 392,735	$ 11,092	$ 27,491
$400,000 - $999,999	0.0	$ -	$ -	$ -	$ -
$1,000,000 +	0.0	$ -	$ -	$ -	
Sum (check figures)	63	$ 4,933,818		$ 698,817	$ 345,367

** allocation method used, medical only.

Salary Table
For the Employer Portion of Health Insurance Coverage and Retirement Contributions: This can be a combination of Medical, Dental and Vision – or Medical only. For your hospital specifically, please note at the bottom of the chart exactly what is included.

Also, in the same section of the table you see the words "allocation method allowed". While the Board prefers the actual real amounts, we understand that sometimes that is not possible and in that case, we would accept an allocation based on the number of people. For your hospital, please note at the bottom whether you are reporting real numbers or if the numbers are an allocation.

FY20 Budget Submission - OCV Salary Table
Salary Table 10/18/2019 Page 1 of 1

Notes:

Version	Submitted to GMCB
FY21 Salary and Benchmark Information	03/30/21

20) Audited Financial Statements

Report Purpose: To submit audited financial information and note disclosures for prior time periods to evaluate budget to actual performance and other review.

Deadline: (Annual) Sept.

Instructions: Submit audited financial statements as soon as they are available. OneCare must crosswalk submitted actuals per its budget submission to audited financial statements.

Definitions:

Report Template: Audited financials must be submitted per financial audit standards. Template for crosswalk will be provided by the GMCB (see report #21).

Notes:

Version	**Submitted to GMCB**
FY20 Audited Financials	09/30/20
FY21 Audited Financials	Upcoming 09/2021

21) Crosswalk Submitted Actuals to Audited Financial Statements

Report Purpose: Due to different presentation in the budget submissions to the presentation of audited financial statements, this will allow for a reconciliation between the submitted budgets/actuals to what was ultimately audited.

Deadline: Annual (September – with audited financials)

Instructions: Provide a report showing actuals submitted per a budget submission and the changes made to the line items to reconcile to the audited financial statement information. Use columns/rows as necessary to show the numbers being eliminated/added, as well as an explanation as to why numbers are being eliminated/added.

Definitions:

Report Template:

Notes:

Version	**Submitted to GMCB**
FY20 Crosswalk of Audited Financials	09/30/20
FY21 Crosswalk of Audited Financials	Upcoming 09/2021

22) Comprehensive Payment Reform (CPR) Program

Report Purpose: To monitor performance of the CPR program which is designed to allow greater participation from independent primary care providers and bring more providers into a capitated payment model.

Deadline: Annual/Semi-Annual (TBD)

Instructions: Submit a narrative report explaining the status of OneCare's comprehensive payment reform program. Please include detailed information on the program summary, quality outcomes for each participant, and specific fixed payments.

CPR reporting requirements per FY19 Budget Order (M)(N):

(a) compares the 2018 quality outcomes of the pilot cohort with the non-pilot cohort;

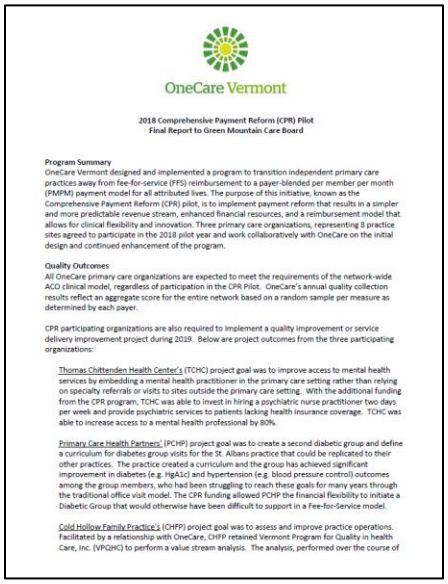
(b) analyzes how the capitated payments received by primary care practices in 2018 under the pilot compared to payments hospitals made to primary care providers that did not participate in the pilot; and

(c) describes practices' experiences with the pilot (e.g., impacts on administrative burden and any clinical innovations allowed by increased flexibility and/or resources).

No later than 30 days after the end of Q2 2019, OneCare must submit an interim financial report on the 2019 CPR program that describes changes made to the program in 2019 and analyzes how the capitated payments received by primary care practices under the program compared to payments hospitals made to primary care providers not participating in the pilot.

Definitions:

Report Template: UNDER REVIEW



OneCare Vermont

2018 Comprehensive Payment Reform (CPR) Pilot
Final Report to Green Mountain Care Board

Program Summary
OneCare Vermont designed and implemented a program to transition independent primary care practices away from fee-for-service (FFS) reimbursement to a payer-blended per member per month (PMPM) payment model for all attributed lives. The purpose of this initiative, known as the Comprehensive Payment Reform (CPR) pilot, is to implement payment reform that results in a simpler and more predictable revenue stream, enhanced financial resources, and a reimbursement model that allows for clinical flexibility and innovation. Three primary care organizations, representing 8 practice sites agreed to participate in the 2018 pilot year and work collaboratively with OneCare on the initial design and continued enhancement of the program.

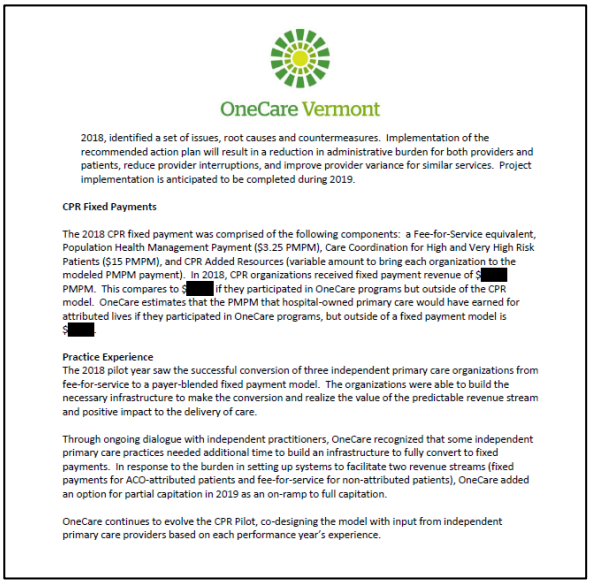
Quality Outcomes
All OneCare primary care organizations are expected to meet the requirements of the network-wide ACO clinical model, regardless of participation in the CPR Pilot. OneCare's annual quality collection results reflect an aggregate score for the entire network based on a random sample per measure as determined by each payer.

CPR participating organizations are also required to implement a quality improvement or service delivery improvement project during 2019. Below are project outcomes from the three participating organizations:

Thomas Chittenden Health Center's (TCHC) project goal was to improve access to mental health services by embedding a mental health practitioner in the primary care setting rather than relying on specialty referrals or visits to sites outside the primary care setting. With the additional funding from the CPR program, TCHC was able to invest in hiring a psychiatric nurse practitioner two days per week and provide psychiatric services to patients lacking health insurance coverage. TCHC was able to increase access to a mental health professional by 80%.

Primary Care Health Partners' (PCHP) project goal was to create a second diabetic group and define a curriculum for diabetes group visits for the St. Albans practice that could be replicated to their other practices. The practice created a curriculum and the group has achieved significant improvement in diabetes (e.g. HgA1c) and hypertension (e.g. blood pressure control) outcomes among the group members, who had been struggling to reach these goals for many years through the traditional office visit model. The CPR funding allowed PCHP the financial flexibility to initiate a Diabetic Group that would otherwise have been difficult to support in a Fee-for-Service model.

Cold Hollow Family Practice's (CHFP) project goal was to assess and improve practice operations. Facilitated by a relationship with OneCare, CHFP retained Vermont Program for Quality in health Care, Inc. (VPQHC) to perform a value stream analysis. The analysis, performed over the course of



OneCare Vermont

2018, identified a set of issues, root causes and countermeasures. Implementation of the recommended action plan will result in a reduction in administrative burden for both providers and patients, reduce provider interruptions, and improve provider variance for similar services. Project implementation is anticipated to be completed during 2019.

CPR Fixed Payments

The 2018 CPR fixed payment was comprised of the following components: a Fee-for-Service equivalent, Population Health Management Payment ($3.25 PMPM), Care Coordination for High and Very High Risk Patients ($15 PMPM), and CPR Added Resources (variable amount to bring each organization to the modeled PMPM payment). In 2018, CPR organizations received fixed payment revenue of $[redacted] PMPM. This compares to $[redacted] if they participated in OneCare programs but outside of the CPR model. OneCare estimates that the PMPM that hospital-owned primary care would have earned for attributed lives if they participated in OneCare programs, but outside of a fixed payment model is $[redacted]

Practice Experience
The 2018 pilot year saw the successful conversion of three independent primary care organizations from fee-for-service to a payer-blended fixed payment model. The organizations were able to build the necessary infrastructure to make the conversion and realize the value of the predictable revenue stream and positive impact to the delivery of care.

Through ongoing dialogue with independent practitioners, OneCare recognized that some independent primary care practices needed additional time to build an infrastructure to fully convert to fixed payments. In response to the burden in setting up systems to facilitate two revenue streams (fixed payments for ACO-attributed patients and fee-for-service for non-attributed patients), OneCare added an option for partial capitation in 2019 as an on-ramp to full capitation.

OneCare continues to evolve the CPR Pilot, co-designing the model with input from independent primary care providers based on each performance year's experience.

Notes:

Version	Submitted to GMCB
2019 CPR Report	08/1/19

23) Settlement Reports

Report Purpose: Year-end reconciliation for payers.

Deadline: Annual (Nov)

Instructions: Complete the settlement report template broken out by payer and HSA. This report must be submitted on an annual basis.

Definitions:

Report Template: UNDER REVIEW

OneCare Vermont
2019 Settlement - HSAs
10/12/2020

	Medicaid							Medicare								
	MRL Limited Savings/(Losses)	Pooling	Recon to Payer-Level Settlement	Risk Mitigation	Medicaid Risk Settlement	FPP Recon due to MEG Changes	Elsewhere Lives FPP Reconciliation	MRL Limited Savings/(Losses)	Pooling	VBIF Contribution	Recon to Payer-Level Settlement	Risk Mitigation	Medicare Cash Settlement	AIPBP Recon	Already Collected For AIPBP Recon	AIPBP Cash Settlement
Bennington/SVMC	$ (648,097)	$ -	$ 378	$ 323,670	$ (324,048)	$ 107,273	$ (32,619)	$ (1,344,535)	$ (97,247)	$ (21,270)	$ (1,897)	$ 48,507	$ (1,416,441)	$ (874,774)		$ (874,774)
Berlin/CVMC	$ 478,852	$ (1,057,658)	$ 338		$ (578,468)	$ 156,503	$ (204,442)	$ (3,038,627)	$ -	$ (23,537)	$ (3,971)		$ (3,066,135)	$ (191,670)		$ (191,670)
Brattleboro/BMH	$ (328,259)	$ -	$ 192	$ 163,938	$ (164,129)	$ 99,491	$ 153,424	$ 776,633	$ (48,752)	$ (11,255)	$ 929	$ (179,389)	$ 538,167	$ (312,898)		$ (312,898)
Burlington/UVMMC	$ 804,643	$ (3,035,173)	$ 1,302		$ (2,229,228)	$ 575,179	$ 573,813	$ 4,607,288	$ (333,457)	$ (80,116)	$ 5,438		$ 4,199,153	$ (5,116,113)		$ (5,116,113)
Lebanon/DHMC	$ (272,441)	$ -	$ 159		$ (272,282)	$ -	$ -									
Middlebury/PMC	$ 244,640	$ (625,250)	$ 222		$ (380,388)	$ 57,350	$ 65,567	$ 1,479,303	$ (67,174)	$ (15,796)	$ 1,811		$ 1,398,144	$ 642,937		$ 642,937
Newport/NCH	$ (412,092)	$ -	$ 241		$ (411,851)	$ 74,553	$ 129,147									
Randolph/GMC	$ (312,184)	$ -	$ 182		$ (312,001)	$ 39,188	$ (163,677)									
Rutland/RMC	$ (892,786)	$ -	$ 521		$ (892,265)	$ 206,357	$ (93,511)									
Springfield/SH	$ (456,468)	$ -	$ 266	$ 227,968	$ (228,234)	$ 66,551	$ 389,810	$ 1,206,628	$ (57,346)	$ (13,322)	$ 1,473	$ (284,358)	$ 853,075	$ (260,700)	$ 46,210	$ (214,490)
St. Albans/NMC	$ 834,128	$ (1,668,256)	$ 487		$ (833,641)	$ 111,325	$ (1,006,225)	$ 302,395	$ (92,161)	$ (20,237)	$ 246		$ 190,243	$ (3,798)		$ (3,798)
St. Johnsbury/NVRH	$ (625,990)	$ -	$ 365		$ (625,624)	$ 68,476	$ (3,845)									
Windsor/Mt A	$ (145,015)	$ -	$ 85		$ (144,930)	$ 45,128	$ 192,557	$ (12,432)	$ (49,175)	$ (11,225)	$ (94)		$ (72,927)	$ (504,904)		$ (504,904)
OCV	$ (1,731,069)	$ (6,386,337)	$ 4,739	$ 715,576	$ (7,397,091)	$ 1,607,374	$ (0)	$ 3,976,653	$ (745,312)	$ (196,758)	$ 3,935	$ (415,240)	$ 2,623,278	$ (6,621,921)	$ 46,210	$ (6,575,711)

Notes:

Version	Submitted to GMCB
FY19 Settlement Report	11/11/20
FY20 Settlement Report	Upcoming 2021
FY21 Settlement Report	Upcoming 2022

24) Complaint and Grievance Report

Report Purpose: Per GMCB Rule 5.000, § 5.208(i) it is required that all certified ACOs submit complaint and grievance reports to the GMCB and Health Care Advocate no less than twice a year.

Deadline: Due semi-annually (July and January).

Instructions: UNDER REVIEW

1. Complete and submit the Excel template.
2. Provide notes on the following:
    a. Tracking, monitoring, and reporting (summarize policy/procedure)
    b. Primary drivers for patient/provider customer service
    c. Count of inquiries, complaints, grievances
    d. Escalation

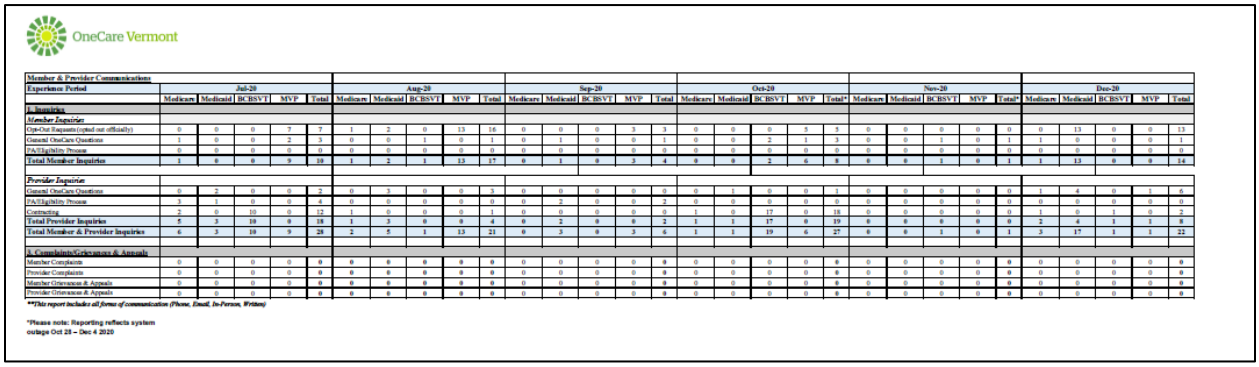
Definitions:

Inquiry – Definition from OneCare

Complaint – Definition from OneCare

Grievance – Definition from OneCare

Report Template: UNDER REVIEW

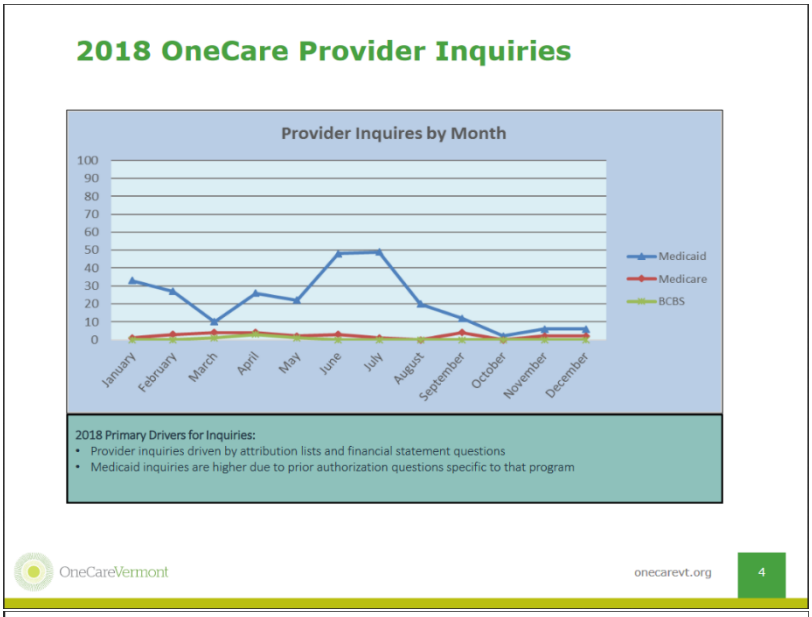


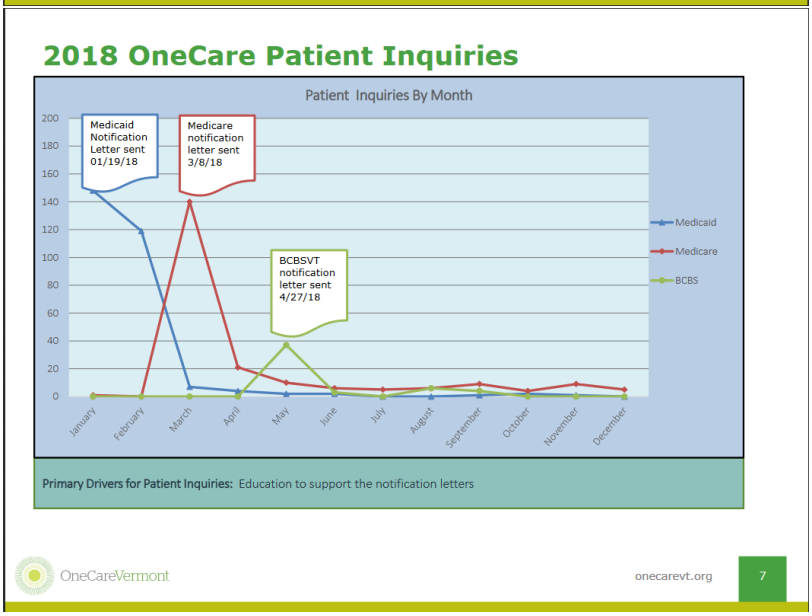
OneCare Vermont

Member & Provider Communications Experience Period	Jul-20					Aug-20					Sep-20					Oct-20					Nov-20					Dec-20				
	Medicare	Medicaid	BCBSVT	MVP	Total	Medicare	Medicaid	BCBSVT	MVP	Total	Medicare	Medicaid	BCBSVT	MVP	Total	Medicare	Medicaid	BCBSVT	MVP	Total*	Medicare	Medicaid	BCBSVT	MVP	Total*	Medicare	Medicaid	BCBSVT	MVP	Total
A. Inquiries																														
Member Inquiries																														
Opt-Out Requests (opted out officially)	0	0	0	7	7	1	2	0	13	16	0	0	0	3	3	0	0	0	5	5	0	0	0	0	0	0	13	0	0	13
General OneCare Questions	1	0	0	2	3	0	0	1	0	1	0	1	0	0	1	0	0	2	1	3	0	0	1	0	1	1	0	0	0	1
PA/Eligibility Process	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Member Inquiries	**1**	**0**	**0**	**9**	**10**	**1**	**2**	**1**	**13**	**17**	**0**	**1**	**0**	**3**	**4**	**0**	**0**	**2**	**6**	**8**	**0**	**0**	**1**	**0**	**1**	**1**	**13**	**0**	**0**	**14**
Provider Inquiries																														
General OneCare Questions	0	2	0	0	2	0	3	0	0	3	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	4	0	1	6
PA/Eligibility Process	3	1	0	0	4	0	0	0	0	0	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contracting	2	0	10	0	12	1	0	0	0	1	0	0	0	0	0	1	0	17	0	18	0	0	0	0	0	1	0	1	0	2
Total Provider Inquiries	**5**	**3**	**10**	**0**	**18**	**1**	**3**	**0**	**0**	**4**	**0**	**2**	**0**	**0**	**2**	**1**	**1**	**17**	**0**	**19**	**0**	**0**	**0**	**0**	**0**	**2**	**4**	**1**	**1**	**8**
Total Member & Provider Inquiries	**6**	**3**	**10**	**9**	**28**	**2**	**5**	**1**	**13**	**21**	**0**	**3**	**0**	**3**	**6**	**1**	**1**	**19**	**6**	**27**	**0**	**0**	**1**	**0**	**1**	**3**	**17**	**1**	**1**	**22**
A. Complaints/Grievances & Appeals																														
Member Complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Provider Complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Member Grievances & Appeals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Provider Grievances & Appeals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

***This report includes all forms of communication (Phone, Email, In-Person, Written)*

*Please note: Reporting reflects system outage Oct 28 – Dec 4 2020





OneCare Vermont Update For PY 2018

Notes: This report is known as the “Member & Provider Communications Report” by OneCare and called a “complaint and grievance report” in the Rule.

Version	Submitted to GMCB
FY20 Complaint and Grievance	07/31/20, 01/31/21
FY21 Complaint and Grievance	Upcoming 07/31/20

25) Beneficiary Notification Letters

Report Purpose: Per GMCB Rule 5.000, § 5.208(j) it is required that all certified ACOs alert individuals that are attributed to the ACO network that they are an ACO beneficiary. The GMCB requires that a copy of the notification letters from each payer sent to the beneficiaries be provided.

Deadline: Annual (March)

Instructions: OneCare must submit beneficiary notification letters on an annual basis. The GMCB must be notified should any changes be made to letters. Revised copies must be submitted within 15 days of revisions.

Definitions:

Report Template: None.

Notes:

Version	Submitted to GMCB
FY21 Beneficiary Notification Letters	04/29/21

26) Policies, Procedures, Plans Checklist

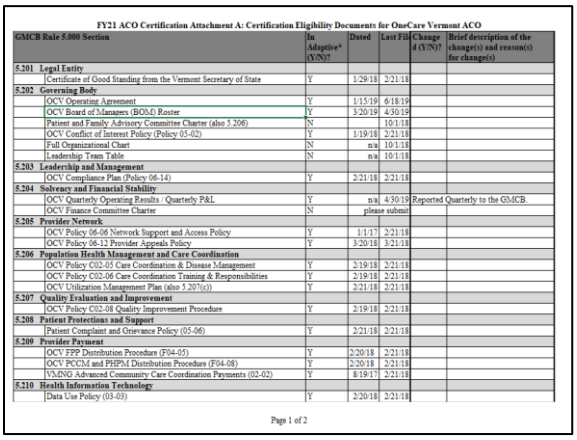
Report Purpose: GMCB Rule 5.000 requires that all certified ACOs in Vermont maintain specific standards and operational procedures. To validate that an ACO is meeting requirements laid out in Rule 5.000, the GMCB requires that policies, procedures, and plans be submitted on a monthly basis. The GMCB verifies criteria in Rule 5.000 is being met by evaluating policies, procedures, and plans.

Deadline: Due annually with Certification Verification Form submission. Policies, etc. are reported monthly to the GMCB as adopted by the ACO Board of Managers.

Instructions: Complete the following templates, one of which details all policies and procedures on OneCare's books, and one of which details policies and procedures specific to direct criteria listed in Rule 5.000.

Definitions: None.

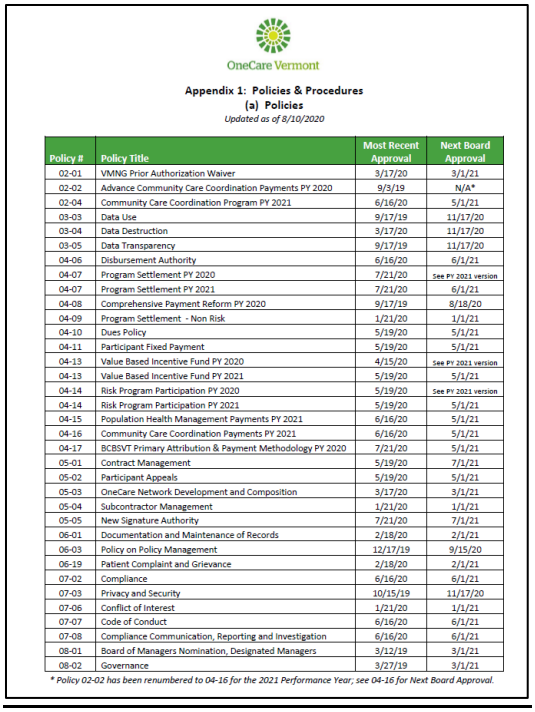
Report Template:



FY21 ACO Certification Attachment A: Certification Eligibility Documents for OneCare Vermont ACO

GMCB Rule 5.000 Section		In Adaptive* (Y/N)?	Dated	Last Filed	Changed (Y/N)?	Brief description of the change(s) and reason(s) for change(s)
5.201 Legal Entity						
	Certificate of Good Standing from the Vermont Secretary of State	Y	1/29/18	2/21/18		
5.202 Governing Body						
	OCV Operating Agreement	Y	1/15/19	6/18/19		
	OCV Board of Managers (BOM) Roster	Y	3/20/19	4/30/19		
	Patient and Family Advisory Committee Charter (also 5.206)	N		10/1/18		
	OCV Conflict of Interest Policy (Policy 05-02)	Y	1/19/18	2/21/18		
	Full Organizational Chart	N	n/a	10/1/18		
	Leadership Team Table	N	n/a	10/1/18		
5.203 Leadership and Management						
	OCV Compliance Plan (Policy 06-14)	Y	2/21/18	2/21/18		
5.204 Solvency and Financial Stability						
	OCV Quarterly Operating Results / Quarterly P&L	Y	n/a	4/30/19	Reported Quarterly to the GMCB.	
	OCV Finance Committee Charter	N	please submit			
5.205 Provider Network						
	OCV Policy 06-06 Network Support and Access Policy	Y	1/1/17	2/21/18		
	OCV Policy 06-12 Provider Appeals Policy	Y	3/20/18	3/21/18		
5.206 Population Health Management and Care Coordination						
	OCV Policy C02-05 Care Coordination & Disease Management	Y	2/19/18	2/21/18		
	OCV Policy C02-06 Care Coordination Training & Responsibilities	Y	2/19/18	2/21/18		
	OCV Utilization Management Plan (also 5.207(c))	Y	2/21/18	2/21/18		
5.207 Quality Evaluation and Improvement						
	OCV Policy C02-08 Quality Improvement Procedure	Y	2/19/18	2/21/18		
5.208 Patient Protections and Support						
	Patient Complaint and Grievance Policy (05-06)	Y	2/21/18	2/21/18		
5.209 Provider Payment						
	OCV FPP Distribution Procedure (F04-05)	Y	2/20/18	2/21/18		
	OCV PCCM and PHPM Distribution Procedure (F04-08)	Y	2/20/18	2/21/18		
	VMNG Advanced Community Care Coordination Payments (02-02)	Y	8/19/17	2/21/18		
5.210 Health Information Technology						
	Data Use Policy (03-03)	Y	2/20/18	2/21/18		

Page 1 of 2



OneCare Vermont

Appendix 1: Policies & Procedures
(a) Policies
Updated as of 8/10/2020

Policy #	Policy Title	Most Recent Approval	Next Board Approval
02-01	VMNG Prior Authorization Waiver	3/17/20	3/1/21
02-02	Advance Community Care Coordination Payments PY 2020	9/3/19	N/A*
02-04	Community Care Coordination Program PY 2021	6/16/20	5/1/21
03-03	Data Use	9/17/19	11/17/20
03-04	Data Destruction	3/17/20	11/17/20
03-05	Data Transparency	9/17/19	11/17/20
04-06	Disbursement Authority	6/16/20	6/1/21
04-07	Program Settlement PY 2020	7/21/20	See PY 2021 version
04-07	Program Settlement PY 2021	7/21/20	6/1/21
04-08	Comprehensive Payment Reform PY 2020	9/17/19	8/18/20
04-09	Program Settlement - Non Risk	1/21/20	1/1/21
04-10	Dues Policy	5/19/20	5/1/21
04-11	Participant Fixed Payment	5/19/20	5/1/21
04-13	Value Based Incentive Fund PY 2020	4/15/20	See PY 2021 version
04-13	Value Based Incentive Fund PY 2021	5/19/20	5/1/21
04-14	Risk Program Participation PY 2020	5/19/20	See PY 2021 version
04-14	Risk Program Participation PY 2021	5/19/20	5/1/21
04-15	Population Health Management Payments PY 2021	6/16/20	5/1/21
04-16	Community Care Coordination Payments PY 2021	6/16/20	5/1/21
04-17	BCBSVT Primary Attribution & Payment Methodology PY 2020	7/21/20	5/1/21
05-01	Contract Management	5/19/20	7/1/21
05-02	Participant Appeals	5/19/20	5/1/21
05-03	OneCare Network Development and Composition	3/17/20	3/1/21
05-04	Subcontractor Management	1/21/20	1/1/21
05-05	New Signature Authority	7/21/20	7/1/21
06-01	Documentation and Maintenance of Records	2/18/20	2/1/21
06-03	Policy on Policy Management	12/17/19	9/15/20
06-19	Patient Complaint and Grievance	2/18/20	2/1/21
07-02	Compliance	6/16/20	6/1/21
07-03	Privacy and Security	10/15/19	11/17/20
07-06	Conflict of Interest	1/21/20	1/1/21
07-07	Code of Conduct	6/16/20	6/1/21
07-08	Compliance Communication, Reporting and Investigation	6/16/20	6/1/21
08-01	Board of Managers Nomination, Designated Managers	3/12/19	3/1/21
08-02	Governance	3/27/19	3/1/21

** Policy 02-02 has been renumbered to 04-16 for the 2021 Performance Year; see 04-16 for Next Board Approval.*

Notes: None.

Version	Submitted to GMCB
FY19 Policies and Procedures Checklist	09/1/18
FY20 Policies and Procedures Checklist	09/1/19
FY21 Policies and Procedures Checklist	09/1/20
FY22 Policies and Procedures Checklist	Upcoming 2021

27) Operating Agreement

Report Purpose: Per GMCB Rule 5.000, § 5.501(c) it is required that all certified ACOs submit their operating agreement or bylaws to the regulating entity within 15 days of any changes.

Deadline: Due annually with Certification Verification Form submission or within 15 days of any changes.

Instructions: Through the ACO Certification Verification Form, ACOs are required to notify and submit any changes made to operating agreements and bylaws, within 15 days of their occurrence.

Definitions: None.

Report template: No standard template required.

Notes: The GMCB tracks the operating agreement by filing the initial document from the initial certification process and all amendments henceforth.

Operating Agreement Log:

Version	Date Adopted	Submitted to GMCB
OCV 4th Amended Operating Agreement	06/20/17	02/22/18
OCV 6th Amended Operating Agreement	01/15/19	06/18/19
5.202 OCV Operating Agreement	04/15/20	07/22/20

28) Governance, Leadership, and Organizational Charts

Report Purpose: Per GMCB Rule 5.000, § 5.202, it is required that certified ACOs "must have a governance structure that reasonably and equitably represents ACO participants." To verify ACOs continue to meet this requirement, the GMCB asks for the submission of a governance chart. ACOs must also submit leadership and organizational charts to satisfy the requirements laid out in GMCB Rule 5.000, § 5.203.

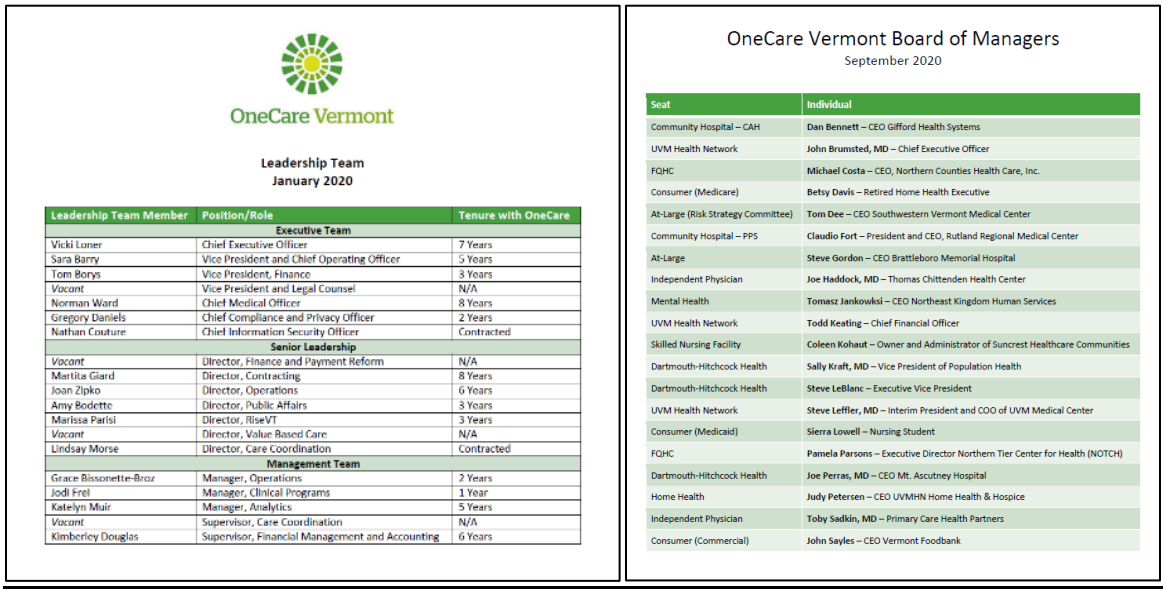
Deadline: Due annually with Certification Verification Form submission or within 15 days of any changes (5.501(c)).

Instructions: Submit the following documents:

1. Leadership Team Chart
2. Organizational Chart
3. Governance Structure Chart
4. Board of Managers Roster

In narrative form, please briefly provide an update on any vacancies (length position is vacant, status update of search to fill the position, etc.) indicated in any of the three charts.

Report Template:



OneCare Vermont

Leadership Team
January 2020

Leadership Team Member	Position/Role	Tenure with OneCare
Executive Team		
Vicki Loner	Chief Executive Officer	7 Years
Sara Barry	Vice President and Chief Operating Officer	5 Years
Tom Borys	Vice President, Finance	3 Years
Vacant	Vice President and Legal Counsel	N/A
Norman Ward	Chief Medical Officer	8 Years
Gregory Daniels	Chief Compliance and Privacy Officer	2 Years
Nathan Couture	Chief Information Security Officer	Contracted
Senior Leadership		
Vacant	Director, Finance and Payment Reform	N/A
Martita Giard	Director, Contracting	8 Years
Joan Zipko	Director, Operations	6 Years
Amy Bodette	Director, Public Affairs	3 Years
Marissa Parisi	Director, RiseVT	3 Years
Vacant	Director, Value Based Care	N/A
Lindsay Morse	Director, Care Coordination	Contracted
Management Team		
Grace Bissonette-Broz	Manager, Operations	2 Years
Jodi Frei	Manager, Clinical Programs	1 Year
Katelyn Muir	Manager, Analytics	5 Years
Vacant	Supervisor, Care Coordination	N/A
Kimberley Douglas	Supervisor, Financial Management and Accounting	6 Years

OneCare Vermont Board of Managers
September 2020

Seat	Individual
Community Hospital – CAH	**Dan Bennett** – CEO Gifford Health Systems
UVM Health Network	**John Brumsted, MD** – Chief Executive Officer
FQHC	**Michael Costa** – CEO, Northern Counties Health Care, Inc.
Consumer (Medicare)	**Betsy Davis** – Retired Home Health Executive
At-Large (Risk Strategy Committee)	**Tom Dee** – CEO Southwestern Vermont Medical Center
Community Hospital – PPS	**Claudio Fort** – President and CEO, Rutland Regional Medical Center
At-Large	**Steve Gordon** – CEO Brattleboro Memorial Hospital
Independent Physician	**Joe Haddock, MD** – Thomas Chittenden Health Center
Mental Health	**Tomasz Jankowksi** – CEO Northeast Kingdom Human Services
UVM Health Network	**Todd Keating** – Chief Financial Officer
Skilled Nursing Facility	**Coleen Kohaut** – Owner and Administrator of Suncrest Healthcare Communities
Dartmouth-Hitchcock Health	**Sally Kraft, MD** – Vice President of Population Health
Dartmouth-Hitchcock Health	**Steve LeBlanc** – Executive Vice President
UVM Health Network	**Steve Leffler, MD** – Interim President and COO of UVM Medical Center
Consumer (Medicaid)	**Sierra Lowell** – Nursing Student
FQHC	**Pamela Parsons** – Executive Director Northern Tier Center for Health (NOTCH)
Dartmouth-Hitchcock Health	**Joe Perras, MD** – CEO Mt. Ascutney Hospital
Home Health	**Judy Petersen** – CEO UVMHN Home Health & Hospice
Independent Physician	**Toby Sadkin, MD** – Primary Care Health Partners
Consumer (Commercial)	**John Sayles** – CEO Vermont Foodbank

Version	Submitted to GMCB
FY19 Leadership and Org. Charts	09/1/18
FY20 Leadership and Org. Charts	09/1/19
FY21 Leadership and Org. Charts	09/1/20
FY22 Leadership and Org. Charts	Upcoming 2021

29) Committee Charters

Report Purpose: Per GMCB Rule 5.000, § 5.301(c)(2)(g), through the initial ACO certification process, ACOs are required to submit "descriptions of the purpose and composition of each of the [ACO's] committees, advisory boards, councils, and similar groups." The GMCB upholds this standard by collecting committee charters as needed.

Deadline: Annual (September 1 – Certification)

Instructions: Submit a list and description of all current committees under OneCare's governance structure. Supply the GMCB with specific committee charters as requested that have been updated or revised since the last submission date.

OneCare committees:

- Executive Committee
- Finance Committee
- Population Health Strategy Committee
- Patient and Family Advisory Committee
- Clinical and Quality Advisory Committee
- Pediatric Subcommittee
- Laboratory Subcommittee
- Prevention and Health Promotion Committee
- Audit Committee

Definitions: None.

Report Template: No specified template.

Notes: None.

Version	Submitted to GMCB
FY19 Committee Charters	09/1/18
FY20 Committee Charters	09/1/19
FY21 Committee Charters	09/1/20
FY22 Committee Charters	Upcoming 2021

30) Demonstration of Data Analytics

Report Purpose: To describe and demonstrate the ACO's health information technology systems and how these systems are used by the ACO, e.g., to coordinate care and measure performance, to support data collection and integration and data analytics.

Deadline: ad-hoc

Instructions:

Definitions:

Report Template:

Notes:

Version	Date
2018	2/20/2018
2021	(scheduled)

31) Fixed Prospective Payment Target and Strategy

Report Purpose: OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.

Deadline: July 1, 2021

Instructions:

OneCare must submit a report to the GMCB on FY21 Budget Order Condition #15.

FY21 OneCare ACO Budget Order Condition #15:

OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.

Deliverable:

By July 1, 2021 OneCare must submit a report to the GMCB including:

A. Targets for percent of contract revenue in fixed prospective payments, by payer program. Include a baseline year, the calculated percent of contract revenue in fixed prospective payments for the baseline year, and achievable targets for FY22 through FY25.
B. A strategy for achieving the targets, by payer, with timelines, clear goals, and milestones. Include discussion of limitations or other factors by payer.
C. A description of how OneCare calculates the percent of revenue in fixed prospective payments, using the LAN definitions below. Fixed prospective payments are those that fit the definitions found within the shaded box. OneCare must break out the payment types according to those categories.
D. The report from OneCare may also include discussion of other payment models OneCare is implementing to reduce reliance on fee-for-service and achieve the goals of value-based care to reduce costs and improve quality of care. OneCare may include a calculation of the precent of revenue in other alternative payment models, using the definitions below. However, the revenue in fixed prospective payments is the focus of the report and must be clearly defined and calculated.
    - Discussion may include: What types of payments work best for different provider types? What other provider types does it make sense to evolve the payment models to, e.g., FQHCs? What other payment types are out there?

Definitions:

Health Care Payment Models:

Definitions adapted from the Learning Action Network's Alternative Payment Model Framework.

Fee-for-service (FFS) – Traditional, no link to Quality/Value: payments are made to providers to deliver a service without providing an incentive to improve quality or reduce costs.

Fee-for-service (FFS) – link to Quality/Value: uses traditional FFS payment but adds incremental incentives or disincentives for performance on quality, patient satisfaction, efficiency, or for participation in activities that could improve care. Examples include FFS supplemented with care coordination/HIT payments, pay for reporting, and pay for performance.

Alternative Payment Models (APM)

FFS with Shared Savings: uses traditional FFS payment but holds savings "at risk" for performance on quality and total cost of care

FFS with Shared Savings and Losses: uses traditional FFS payment but holds provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality.

Fixed prospective payment (FPP) with FFS reconciliation and Shared Savings and Losses: pays a fixed prospective payment, often monthly, with a year-end reconciliation against the FFS equivalent, and holds the provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality (e.g. Vermont Medicare ACO Initiative)

FPP with Shared Savings and Losses: pays a fixed prospective payment, and holds the provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality (e.g. Vermont Medicaid Next Generation)

Population-Based Payment: prospective payment to providers for "all care", with quality incentives playing a central role.

(*Definitions adapted from the Learning Action Network's Alternative Payment Model Framework.)

Other Population Health or Health Care Reform Payments:

Care Coordination Payment: Payments for the organization of patient care activities, including information sharing among a patient's care team, in order to achieve safer and more effective care with the goal of improving a patient's health outcomes.

ACO Population Health Management (PHM): PHM payments delivered through the ACO are intended to maximize health outcomes, and support value-based care objectives. PHM payments can be fixed or variable, depending on whether a recipient assumes risk during participation. OneCare has a variable population health management payment program for risk-based programs.

Blueprint for Health: OneCare administers payments to Blueprint for Health participating providers for two key programs: Primary Care Medical Home (PCMH) and Community Health Teams (CHT). The only program that receives PCMH payments is Medicare and eligibility is based on attribution. The payment for FY21 PCMH is $2.05 PMPM. The FY21 CHT payments are $2.56 PMPM and is paid through the Medicare program directly to the Blueprint entity within that HSA.

ACO Shared Savings/Losses: Shared savings and losses is a payment strategy that incentivizes providers to reduce health care costs for their patient population in which the ACO

offers providers a portion of net savings for their efforts to reduce spending for their population, or losses if spending ends up being more than expected. This payment methodology is designed to tie payment to ACO or provider performance.

Other Value Based Infrastructure Payments: Payments or incentives to providers to invest in infrastructure expected to improve patient care (e.g. EMR/HIT investments).

Report template:

Notes:

Version	**Submitted to GMCB**
One-time submission of FPP Target and Strategy	Due upcoming on 07/1/2021

32) ACO Return on Investment Analysis

Report purpose: Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

Deadline: TBD 2023

Instructions: UNDER DEVELOPMENT

Definitions:

Report Template:

Notes:

Version	Submitted to GMCB
One-time submission of ACO Return on Investment Analysis	Due upcoming in 2023

33) ACO Strategic Plan

Report purpose: To report the ACO's mission, vision, values, and core strategies and capabilities.

Deadline:

Instructions:

Definitions:

Report template:

Notes:

Version	Submitted to GMCB
2021-2023	5/24/2021